Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration

Occupational Therapy Program

Billing Instructions

ProviderOne Readiness Edition

[WAC 388-545-0300]

About This Publication

This publication supersedes all previous Department/HRSA *Occupational Therapy Program Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School-Based Healthcare Services
- Neurodevelopmental Centers
- Outpatient Hospital Services

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

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How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to the Occupation Therapy Program. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Physical, Occupational and Speech Therapy Limitation Extension Request Form, DSHS 13-786, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by the Department for specific services, supplies, or equipment.

Medical Identification card(s) – See *Services Card*.

Medically Necessary – See WAC 388-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Revised Code of Washington (RCW) - Washington State laws.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Usual and Customary Fee - The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Occupational Therapy

Who Is Eligible to Provide Occupational Therapy?
[WAC 388-545-0300(1)]

The following providers are eligible to enroll with the Department to provide occupational therapy services:

- A licensed occupational therapist;
- A licensed occupational therapy assistant supervised by a licensed occupational therapist; or
- An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

Referral and Documentation Process

Adults (Age 21 and older) [WAC 388-545-0300 (3)(f)]

A provider must prescribe the occupational therapy services. The therapy must:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Be part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for occupational therapy; and
- Document the medical need and the referral in the child's occupational therapy file.

The occupational therapist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT screening provider for information concerning the need for occupational therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Client Eligibility

Who Is Eligible? [WAC 388-545-0300 (2)]

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

The Department pays only for covered occupational therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What Is Covered? [WAC 388-545-0300 (5)(6)]

Unlimited occupational therapy program visits for clients 20 years of age and younger.

The Department covers the following services per client, per calendar year:

- One (1) occupational therapy evaluation;
- One (1) occupational therapy re-evaluation;
- Two (2) durable medical equipment (DME) needs assessments;
- Twelve (12) occupational therapy program visits;
- Twenty-four (24) additional occupational therapy program visits (see next page).

Additional Coverage (Client 21 years of age and older) [WAC 388-545-0300(5)(e)]

The Department will cover a maximum of 24 occupational therapy program visits in addition to the original 12 visits only when billed with one of the following:

- **Principle** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
749-749.25	Severe oral/motor problems that interfere with adequate nutrition (infants) and cleft palate and cleft lip
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Physical Medicine & Rehabilitation (PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
952.8-952.9	Spinal Cord Injury, (Paraplegia & Quadriplegia)
900.82, 344.0, 344.1	
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss, for Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
897.6-897.7, 887.6-887.7	Bilateral Limb Loss

Visit Limitations

Visits are based on the CPT code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

If time is included in the CPT code description the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following CPT codes are considered occupational therapy program visits and are part of the 12-visit limitation:

97014	**97032**	**97110**	**97113**	**97150**	**97535**
97018	**97034**	**97112**	**97140**	**97530**	**97537**

Note: Two 15-minute increments, in any combination (same or different) of the above codes, will be counted as one occupational therapy visit.

97532	97533

Note: Each 15-minute increment of cognitive skills will be counted as one occupational therapy program visit.

The following are not included in the 12-visit limitation:

Modifier	Code	Policy
	97003	Allowed once per calendar year, per client.
	97004	Allowed once per calendar year, per client.
	97762	Providers must bill this code for DME assessments. Payment is limited to two assessments per calendar year, with two 15-minute increments (units) per session.
TS	97762	Providers must bill this code for DME assessments. Payment is limited to two assessments per calendar year, with two 15-minute increments (units) per session. **Use TS Modifier for follow-up service.**
	97760	Two 15-minute increments are allowed per day. Procedure code 97504 can be billed alone or with other occupational therapy CPT codes.

Duplicate services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

How Do I Request Approval to Exceed the Limits?

For clients 21 years of age and older who need occupational therapy in addition to that which is allowed by diagnosis, the provider must request Department approval to exceed the limits.

Limitation extensions (LE) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

Note: Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in Department/HRSA billing instructions and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers will be subject to post payment review.

In cases where the EPA criteria cannot be met and the provider still feels that additional services are medically necessary, the provider must request Department approval for limitation extension. The request must state the following in writing:

1. The name and ProviderOne Client ID of the client;
2. The therapist's name, NPI, and fax number;
3. The prescription for therapy;
4. The number of visits used during that calendar year;
5. The number of additional visits needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and CPT code; and
10. The place of service.

Send your request to the Department (see the Important Contacts section).

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill the Department for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must create a **9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for additional occupational therapy visits for a client who has used 12 OT visits this calendar year and subsequently has had hand surgery would be **870000644** (**870000** = first 6 digits of all expedited prior authorization numbers, **644** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must maintain documentation in the client's file to support how the expedited criteria were met, and have this information available to the Department on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Occupational Therapy (OT) LEs

OCCUPATIONAL THERAPY

CPT: 97014, 97018, 97032, 97034, 97110, 97112, 97113, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97761

Code	Criteria
644	**An additional 12 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has **one** of the following: 1. Hand\Upper Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation
645	**An additional 24 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

Are School-Based Healthcare Services Covered?

The Department covers occupational therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to the current Department/HRSA *School-Based Healthcare Services Billing Instructions*. See the *Important Contacts* Section.

What Is Not Covered? **[WAC 388-545-0300 (7)]**

The Department does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is no limited to, hospital inpatient and nursing facility services.

Coverage Table and Fee Schedule

Note: Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT™ code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
95831		Limb muscle testing, manual		
95832		Hand muscle testing, manual		
95833		Body muscle testing, manual		
95834		Body muscle testing, manual		
95851		Range of motion measurements		
95852		Range of motion measurements		
96125		Cognitive test by hc pro		Limit of one per calendar year, per client
97003		OT evaluation		Limit of one per calendar year, per client
97004		OT re-evaluation		Limit of one per calendar year, per client
97010		Hot or cold packs therapy		Bundled service
97014*		Electric stimulation therapy		
97018*		Paraffin bath therapy		
97032*		Electrical stimulation		
97034*		Contrast bath therapy		
97110*		Therapeutic exercises		
97112*		Neuromuscular reeducation		
97113*		Aquatic therapy/exercises		
97140*		Manual therapy		
97150*		Group therapeutic procedures		
97530*		Therapeutic activities		
97532*		Cognitive skills development		Each 15 minute increment will be counted as one occupational therapy visit

Asterisk (*) means the code is included in the 12 visit limitation (applies to clients 21 and over). Two 15-minute increments, in any combination of these codes will be counted as one occupational therapy visit except as noted above.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
97533*		Sensory integration		Each 15 minute increment will be counted as one occupational therapy visit
97535*		Self care mngment training		
97537*		Community/work reintegration		
97542		Wheelchair mngment training		Use this code for wheelchair needs assessment. Limit is one assessment per calendar year, with four 15-minute increments (units).
97597		Active wound care/20 cm or <		Do not bill with 97598 or 97602 for **same** wound. Do not use in combination with 11040-11044. Limit is one unit per client, per day.
97598		Active wound care > 20 cm		Do not bill with 97597 or 97602 for **same** wound. Do not use in combination with 11040-11044. Limit is one unit per client, per day.
97602		Wound(s) care non-selective		Do not bill with 97597 or 97598 for same wound. Do not use in combination with 11040-11044. Limit is one unit per client, per day.
97750		Physical performance test		
97755		Assistive technology assess	PA	
97760		Orthotic mgmt and training		
97761*		Prosthetic training		

Asterisk (*) means the code is included in the 12 visit limitation (applies to clients 21 and over). Two 15-minute increments, in any combination of these codes will be counted as one occupational therapy visit except as noted above.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
97762		C/o for orthotic/prosth use		Use this code for DME assessments. Limit is two assessments per calendar year, with two 15-minute increments (units) per session.
97762	TS	C/o for orthotic/prosth use		Use this code for DME assessments. Limit is two assessments per calendar year, with two 15-minute increments (units) per session. **Use modifier TS for follow-up service.**
97799	RT or LT	Physical medicine procedure		Use this code for custom hand splints. Limited to one per hand, per year. Use modifier to indicate right or left hand.

Fee Schedule

You may view the Department/HRSA **Occupational Therapy Program Fee Schedule** on-line at:

http://hrsa.dshs.wa.gov/RBRVS/Index.html

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to the Occupational Therapy Program:

Field No.	Name	Entry
24B.	Place of Service	These are the only appropriate codes for this program: **Code Number** — **To Be Used For** 11 — Office 12 — Home 22 — Outpatient 99 — Other